



EMPLOYER'S JOB DESCRIPTION

Job Title _____

Claim # _____

Employer _____

Claimant _____

Phone # _____

Date _____

Description completed by: _____ Title _____

Essential task description:

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Machinery, tools, equipment and personal protective equipment. **(Please submit MSDS if appropriate.)**

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PHYSICAL DEMANDS

N/A: Not Applicable

S: Seldom (1-10% of the time)

O: Occasional (10-30% of the time)

F: Frequent (30%-70% of the time)

C: Constant (Over 70% of the time)

	Frequency	Description of Task
Sitting		
Standing		
Walking		
Driving		
Lifting ()lb.		
Carrying: ()lb.		
Pushing/Pulling: () lb.		
Climbing Stairs/Ladders		
Bending/twisting at waist		
Kneeling/squatting		
Crouching/Kneeling		
Crawling		
Reaching above shoulder		
Repetitive Motion		
Handling/Grasping		
Fine Finger Manipulation		
Talking		
Hearing		
Seeing		
Other		

FOR PHYSICIAN USE ONLY

Physician Approval No ☐ Yes ☐ Full-time ☐ Part-Time ☐ Hours _____ per week

If part-time, worker is expected to progress to full-time work by (date) _____

Date	Physician Signature	Physician Name
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